

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/11/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

lumbar myelogram with CT scan

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that lumbar myelogram with CT scan is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO 06/20/12

Utilization review determination 05/02/12

Utilization review determination 05/23/12

Discharge summary 08/10/10

Operative report 08/10/10

Clinical records Dr. 09/02/10-04/23/12

MRI lumbar spine 04/28/11

Lumbar myelogram 06/03/11

Post-myelogram CT 06/03/11

Radiographic report lumbar spine 07/11/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who is reported to have sustained work related injuries to his low back on xx/xx/xx. He had severe left lower extremity radicular pain and developed a left foot drop. Imaging studies identified a large left L4-5 disc extrusion with caudal migration. He had surgery on 08/10/10 and underwent a left L4-5 laminectomy and decompression of the L4 and L5 nerve roots with opening of the lateral recesses and foraminotomies. There was excision of a large left L4-5 disc extrusion. Post-operatively he was reported to no longer have any leg pain and was ambulatory in the hall. He was discharged. On 09/02/10, he was noted to have some residual discomfort in the left leg and no evidence of infection. He was reported to walk well and had good strength in the lower extremities. On 04/07/11 he is reported to have developed recurrent radicular symptoms in the left lower extremity. He was referred for an MRI of the lumbar spine on 04/28/11. This study notes facet disease at L1-2, L2-3, and L3-4. There is no evidence of disc herniation, canal stenosis, or neural foraminal encroachment at these levels. At L4-5 there are post-surgical changes including the left

paracentral discectomy. At L5-S1 there was a 2mm disc bulge. When seen in follow-up it was noted that there was no evidence of a recurrent disc extrusion. The claimant was referred for lumbar myelogram on 06/03/11. This myelogram notes that mild narrowing of the L4-5 disc space was present and was otherwise unremarkable. Post-myelogram CT notes a 2mm posterior subluxation of L4 on L5. There is a suggestion of previous left laminectomy at this level. There is mild broad based bulging of the disc causing mild encroachment upon the anterior aspect of the dural sac. The neural foramina and facet joints are maintained. There is a bilateral pars defect present at L5 with no subluxation of L5 on S1.

The records indicate that the claimant was maintained on oral medication. On 07/11/11 he was referred for lumbar flexion extension radiographs, which showed no evidence of acute fracture or subluxation. There is radio lucency over the posterior elements of L5 suggestive of interarticular defects. There is mild to moderate disc space narrowing at the L4-5 level with no evidence of instability. Records indicate that the claimant continued to work through 09/20/11 at which time he was no longer able to continue to perform welding due to severe mechanical pain. The claimant was recommended to undergo additional surgery, which included posterior L4-5 decompression, fusion, and instrumentation. Records indicate that the claimant had progressively increasing pain. There are multiple requests for the performance of an L4-5 fusion. A request was made for MRI of the lumbar spine, which was not approved under utilization review.

Most recent physical examination is dated 04/23/12. The claimant is reported to walk with a flexed posture at the low back. He has paralumbar muscular tightness and the loss of lumbar lordosis. Straight leg raise is reported to be positive at 30 degrees. There is weakness of the bilateral foot and great toe dorsiflexion. He is reported to require large amounts of medications including hydrocodone 10mg, Motrin, and Ambien. It is reported that due to his increased pain and increased neurologic deficit a request will be made for lumbar myelogram with post-myelographic CT scan.

The initial review for the request for lumbar myelogram with CT scan was reviewed on 05/02/12. The reviewer denied the request noting that per Official Disability Guidelines, CT myelography is warranted if an MRI is unavailable, contraindicated, or inconclusive. He notes that the records did not cite any of the given indications for the requested service. He notes that there is no documented summary of all the treatment provided and results achieved and therefore finds the request not medically necessary. On 05/23/12 the appeal request was reviewed. The reviewer notes that the claimant has very severe mechanical lumbosacral pain with bilateral radicular pain and numbness, dysesthesias, and weakness in the legs. He notes that the previous request was non-certified because there were no contraindications reported to preclude the use of MRI. He notes that the documentation of actual conservative treatments rendered along with claimant's objective response to each was not noted. He notes that the records again did not document the reasons that would preclude the use of MRI in this claimant.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The submitted clinical records indicate that the claimant sustained a large disc extrusion at the L4-5 level as a result of work place activity. He was taken to surgery on 08/10/10 and underwent a left L4-5 laminectomy and decompression with discectomy. Post-operatively, he was noted to have improvement. He ultimately returned to a heavy labor type job as a welder. Over time the claimant has developed progressively increasing pain radiating into the left lower extremity. The record does not provide any data regarding interval care to include physical therapy notes. He has largely been treated with oral medications. Prior requests for MRI were not approved under utilization review. Most current examination indicates a progression of neurologic deficit for which advanced imaging would be appropriate. However, there is no clinical indication for CT myelogram of the lumbar spine as the claimant's surgical history does not include instrumentation or hardware, which would obscure MRI. There is no data provided that would necessitate the performance of this invasive study. Therefore, it is the opinion of the reviewer that lumbar myelogram with CT scan is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**